H.R. 9504 — Tax Exempt Hospital Transparency Act

Overview. H.R. 9504 would amend the Internal Revenue Code to require substantially more detailed financial, operational, community-benefit, service-line, advertising, charity-care, and 340B reporting by tax-exempt hospital organizations. The bill was introduced by Representatives Greg Murphy and Lloyd Smucker and referred to the House Committee on Ways and Means.

Top 10 Changes

1. Creates a new Internal Revenue Code Section 6033A requiring tax-exempt hospitals to provide additional information on their annual federal returns.

2. Requires every tax-exempt hospital to explain how it is addressing the needs identified in its latest community health needs assessment and why any needs remain unaddressed.

3. Requires hospitals to submit audited financial statements and their CMS certification numbers or other identifiers prescribed by Treasury.

4. Requires reporting of the cost of financial assistance and the number of completed applications received, approved, and denied.

5. Requires large hospitals to identify their three highest-priority community health needs and report spending, actions, impact, and outcomes for each.

6. Requires large hospitals to separately report spending on quality improvement, nonclinical programming, and other Treasury-defined community benefits.

7. Requires high-revenue hospitals to disclose both Medicare-allowable and Medicare-unallowable advertising expenses.

8. Requires high-revenue hospitals to report gross receipts, costs, and cost-allocation methods for each clinical service line under a standardized federal taxonomy.

9. Requires high-revenue tax-exempt hospitals that are also 340B covered entities to report patient volume by coverage type, aggregate net 340B payments, and program participation and compliance costs.

10. Directs GAO to estimate implementation costs and the income-tax liability the 25 highest-revenue tax-exempt hospitals would owe if they were taxable.

Purpose and Overall Structure

The bill is primarily a transparency and tax-reporting measure. It would not directly impose a new tax, establish a minimum charity-care requirement, cap advertising, restrict 340B participation, or set a mandatory community-benefit spending level. Instead, it would require hospitals to disclose information that could later inform congressional oversight, federal rulemaking, enforcement, and debate over the value of hospital tax exemption.

The proposal establishes three overlapping reporting tiers: requirements for all tax-exempt hospital organizations; added requirements for “large” organizations; and additional requirements for “high-revenue” organizations. A system could fall into both the large and high-revenue categories and therefore be subject to both sets of enhanced disclosures. Required information would be treated as part of the annual return under Internal Revenue Code Section 6033.

Requirements for All Tax-Exempt Hospital Organizations

Every hospital organization subject to Section 501(r) and required to file under Section 6033 would have to describe how it is addressing the needs identified in its most recent community health needs assessment. Any need not being addressed would have to be identified, along with the hospital’s reason for not addressing it.

Each organization would also have to file audited financial statements. A hospital whose financials are included in consolidated system statements could submit the consolidated statements. The hospital would also report its CMS certification number or another identifier required by the Treasury Secretary.

Hospitals would have to report the value, measured at cost, of financial assistance provided under their financial-assistance policies. They would also disclose the number of completed applications received, granted, and denied. For large and high-revenue systems, most of these disclosures would generally be required at both the organization level and separately for each hospital facility, unless Treasury provides otherwise.

Additional Reporting for Large Hospitals

A "large tax-exempt hospital organization" would generally be a tax-exempt hospital with more than 100 staffed inpatient beds, based on a cost report from the current year or any of the three preceding years. Critical access hospitals and rural emergency hospitals would be excluded.

Large hospitals would identify the three highest-priority needs from their latest community health needs assessment. For each priority, the organization would report the amount spent during the year, the actions taken, and the impact of those actions on community health. This creates a direct connection between identified needs, hospital spending, program activity, and claimed results.

Large hospitals would also report spending on quality improvement, nonclinical programming, and other community-benefit categories prescribed by Treasury. "Quality improvement" includes education, training, participation in Medicare quality programs, technical assistance, and similar efforts aimed primarily at improving patient outcomes.

The definition of "nonclinical programming" is broad and includes information technology, hospital administration, human resources, billing and coding, public affairs and communications, government affairs and lobbying, regulatory compliance, financial planning, operations, facilities management, patient experience, patient education, family support, financial counseling, discharge planning, and appointment scheduling. These disclosures generally would also be made at the individual-facility level.

Additional Reporting for High-Revenue Hospitals

Definition of a high-revenue hospital. The bill defines a "high-revenue tax-exempt hospital organization" as an organization that is subject to the hospital requirements of Internal Revenue Code Section 501(r), is required to file an annual return under Section 6033, is neither a critical access hospital nor a rural emergency hospital, and has more than $100 million in annual net patient revenue, determined under a methodology established by the Treasury Secretary. The threshold is based on the net patient revenue of the tax-exempt hospital organization—not its 340B revenue, drug revenue, or pharmacy revenue—and would be adjusted for inflation for taxable years beginning after 2028.

Advertising expenses.

High-revenue hospitals would separately disclose advertising expenses that CMS treats as allowable for cost-reimbursement purposes and advertising expenses treated as unallowable. This would provide a clearer view of total promotional spending and how it is characterized in Medicare cost reporting.

Clinical service-line finances.

High-revenue hospitals would describe each health-service line and report its gross receipts and costs. When expenses are shared among service lines, the hospital would have to explain how those expenses were allocated. A service line generally would be a discrete program, department, specialty, care setting, or category serving a defined population and identifiable within the organization's internal cost-accounting or operational systems.

Any cost center separately identified on the hospital's Medicare cost report would be presumed to be a health-service line. A hospital disputing that classification would bear the burden of showing that the cost center does not meet the statutory criteria.

Within two years after enactment, HHS, in consultation with Treasury, would publish a standardized federal service-line taxonomy. High-revenue hospitals would map their internally defined service lines to this taxonomy, which must be updated at least every five years. A hospital could not avoid reporting a federally designated service line merely because it does not separately track the line internally; it would instead disclose that fact and explain its approach.

340B Drug Pricing Program Reporting

Definition of a high-revenue 340B hospital. The bill does not establish a separate statutory definition for this term. In practical terms, the 340B reporting provisions apply to a hospital organization that satisfies the bill's high-revenue definition—more than $100 million in annual net patient revenue, with the specified rural exclusions—and is also a covered entity described in Section 340B(a)(4) of the Public Health Service Act. Such an organization would report the number of individuals receiving 340B-covered outpatient drugs by insurance type, aggregate net 340B payments, and program participation and compliance costs.

The bill defines aggregate net 340B payment as total payer payments received for a covered outpatient drug minus the applicable 340B ceiling price or, if lower, the hospital's actual acquisition price. This amount is essentially a measure of the gross payment spread associated with 340B drugs before separately reported program costs are considered.

The 340B, advertising, and service-line information would generally be reported at both the organization and individual-facility levels. Treasury would coordinate with CMS on advertising and service-line reporting and with HRSA on 340B reporting. The bill states that these disclosures do not alter the legal application of the 340B statute or the federal tax-exemption rules.

Implementation and Effective Dates

Most requirements would apply to taxable years beginning more than one year after publication of the first standardized service-line taxonomy. Because HHS would have up to two years after enactment to publish that taxonomy, broad implementation could occur several years after enactment. For hospitals that are neither large nor high-revenue, the new financial-assistance spending and application-count requirements would apply to taxable years beginning more than three years after enactment.

Treasury would receive broad authority to issue regulations and establish methodologies for allocating costs among community-health activities, financial assistance, quality improvement, nonclinical programming, and other community-benefit categories. Those allocation rules could materially affect how hospital systems classify and report expenses.

GAO Study and Likely Impact

Three years after enactment, GAO would begin a study estimating the additional federal administrative costs and hospital compliance costs created by the legislation. GAO would also estimate the federal income-tax liability that each of the 25 highest-revenue tax-exempt hospital organizations would owe if it were not exempt from federal income tax.

The bill's principal near-term effect would be a substantial expansion of hospital data collection and disclosure. Large multi-hospital systems would likely need to modify tax reporting, financial-assistance tracking, service-line accounting, cost-allocation procedures, community-benefit measurement, and facility-level reporting systems. The resulting information could give Congress, federal agencies, employers, researchers, patients, and the public a more detailed view of hospital margins, administrative expenses, advertising, charity care, community investments, and 340B revenues.

Source: *H.R. 9504, Tax Exempt Hospital Transparency Act, 119th Congress, introduced June 29, 2026.*